

# Euthanasia—An Overview for Our Time

*A Report by the CMA Committee for Continuing Study of Evolving Trends in Society Affecting Life*

*The Committee for the Continuing Study of Evolving Trends in Society Affecting Life was established by the CMA House of Delegates in 1971, following the consideration of a number of resolutions on the topic of abortion. The committee's charge was broadened, however, to include topics such as euthanasia, bio-medical engineering, medicine and religion, ecology and education. The committee's discussions, as its name indicates can cover a wide range of fields of interest to the medical profession. The following article is the first of several which the committee plans to publish, although the products of its deliberations may take the form of resolutions to future meetings of the House of Delegates.*

THE COMMITTEE ON EVOLVING TRENDS IN SOCIETY AFFECTING LIFE has been charged by the CMA House of Delegates to conduct a study of societal trends affecting the practice of medicine. A concomitant aspect of this study must be the anticipation of possible confrontations between present and future patterns of practice. Foremost is the present need to clarify certain terms which appear to be used interchangeably, thereby leading to confusion and misunderstanding, both within and outside the medical profession.

The technological advances of our generation are testing the nature of medicine and of historical medical traditions and definitions. These changes are creating an ambiguous situation in which, for example, "euthanasia" is equated with the abandonment of extraordinary means for maintaining life. Both the fallacy of the equation and the real questions of the application of "euthanasia" in

medical practice today can be clarified, perhaps, by an examination of the issues with which society is confronted.

Euthanasia has been defined as the *painless putting to death* (Webster's Seventh New Collegiate Dictionary) of persons suffering from incurable illnesses. It has also been described as "mercy-killing." For the purpose of this paper, however, mercy-killing will be defined as positive euthanasia—an intentional, positive act of interference with the natural history of the disease process resulting in the termination of the individual life. It should be noted that, at present, positive euthanasia is nowhere tolerated legally in the Western civilization.

The time-honored Judeo-Christian and medical ethic\* has been to do all in one's power to preserve life.<sup>1</sup> In past times this meant solely allowing

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\*In an address, "The Prolongation of Life" (1957), Pope Pius XII noted that it is incumbent on the physician to take all reasonable and extraordinary means of restoring the spontaneous vital functions and consciousness. "But normally one is held to use only ordinary means—according to circumstances of persons, places, times, and cultures—that is to say, means that do not involve any grave burden for oneself or another." It is the Church's view that a time comes when efforts should stop and death be unopposed.<sup>2</sup>

Also note the Hippocratic Oath, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel."

the patient to die, since the state of the art provided no other course. The original concept of medical care was that of being primarily a nursing and comforting phenomenon. There was seldom any likelihood of actually curing the patient until recent times. The motivation was humane and individualistic. The physician's responsibility was to the patient; primacy for general social concerns over the patient's welfare arose only in times of threat to the community as a whole—as in natural disaster or war. Thus, the ethic of allowing a person to die was based entirely on consideration of the dying patient's state, not on the benefits that could accrue to others. While in former times no one would consider "allowing the patient to die" as an act of euthanasia, in light of today's changes one must call similar acts *negative* euthanasia, the termination of life through non-intervention in the disease process. Though the outcome of positive and negative euthanasia is the same, the intent is different. In the former the agent of death is some other person, in the latter it is the illness. The distinction is important and worth noting.

Time and technological progress have provided the physician with a life-prolonging armamentarium. It is thus that the conflict has arisen between the Judeo-Christian tradition and the sociological trend toward negative euthanasia—a concept unknown but practiced years ago. Prior to discussing the several theories already developed by protagonists of negative euthanasia, it will be helpful to examine the changing definition of the word, death. Medical literature is replete with examples of the difficulty of determining if death has occurred in some cases. From ancient times it was known that when the heart and respiration ceased, the brain would die in a few minutes. Now the traditional signs of life—heartbeat and respiration—can be maintained entirely by machine. Resuscitative and supportive machines restore "life" as judged by ancient standards, even when there is no possibility of the individual recovering consciousness following massive brain damage. Hence, the debate over the status of brain death. Some argue that the determination of brain death is a medical-scientific occurrence—that is, a matter of verifiable fact. Others hold that determining death is a socio-moral question—a matter of what is useful or good for the patient or society.<sup>†</sup> Is "pulling the plug" on the machine

an act of recognition that death has occurred, or a halting of extraordinary means to continue life (negative euthanasia), or is it positive euthanasia? Under the circumstances, the historic definition and criteria of death are obsolete or, at least, need refining.

The most comprehensive criteria for brain death have been proposed by the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death.<sup>1</sup> The Ad Hoc Committee was concerned only with those comatose individuals who have no discernible central nervous system activity (but does not include patients with hypothermia—temperature below 90° F—or under the influence of central nervous system depressants, such as barbiturates) and who are, therefore, within the definition of somatic death. There is a difference between somatic death, which is death of the whole, and necrosis, which is death of a part within a living organism. Irreversible changes of certain vital tissues, particularly those of the central nervous system, cause the death of the organism as an integrated functional unit, and death of the individual.<sup>2,3a,4</sup> The Ad Hoc Committee's criteria are, in simplified form, (1) unresponsivity and unresponsivity to externally applied stimuli and inner need, (2) no movements or breathing, (3) no reflexes, and, when possible, (4) flat electroencephalogram. The tests are repeated at least 24 hours later with no change indicated in the foregoing results.

The Harvard Committee has recommended that, when the patient is hopelessly comatose, the family and all medical staff involved should be informed. "Death is to be declared and *then* the respirator turned off. The decision to do this and the responsibility for it are to be taken by the physician-in-charge, in consultation with one or more physicians who have been directly involved in the case. It is unsound and undesirable to force the family to make the decision."<sup>1</sup> It has further been recommended that, to avoid self-interest, physicians involved in the decision to declare the person dead not be involved in any later decision to transplant organs from the deceased patient.

If the Harvard criteria and procedural recommendations for brain death are accepted, then "pulling the plug" is not even negative euthanasia, but the recognition that death has occurred.

In the event that much controversy were engendered concerning new medical criteria for death, it might be necessary in various states to legislate the matter to avoid arbitrary or situa-

<sup>†</sup>In an address, "The Prolongation of Life" (1957), Pope Pius XII indicated that brain death is a medical problem, and that verification of the moment of death can be determined only by a physician. It is not "within the competence of the Church" to do this.<sup>2</sup>

tionist criteria. The courts traditionally have left medical definitions to physicians. *Black's Law Dictionary* states that death is "The cessation of life; the ceasing to exist; *defined by physicians* as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereupon, such as respiration, pulsation, etc."<sup>1</sup> On May 26, 1972 (Tucker vs. Medical College of Virginia) a jury in Richmond, Virginia accepted the Medical College of Virginia's decision to declare a patient's death, using brain death criteria. The case has far-reaching implications for the medical profession.

Medical technology can significantly prolong the lives of the hopelessly ill and the very old, who increasingly fill hospitals and nursing homes, drain facilities, personnel, and funds, and sometimes cause an acute scarcity of resources for other patients. It is asked by some if it is worthwhile to expend so many resources on terminal patients, or whether it would be better to promote euthanasia and/or allowing such a patient to die so that another patient *with more chance for recovery* can take his place. This is a utilitarian idea, and supplants the traditional humanitarian ethic of allowing a person to die, founded on concern for the individual patient's state, and not on benefits to others.

An analogous situation is the inequity between the scarcity of donors for transplant organs, and the growing number of patients in need of transplant organs for survival. Some such patients are old, have no dependents, or cannot work; others may be younger, have families, or have the potential to work: which patient should receive the transplant? Presuming that the patient wants to prolong his life, or is unable to express his wishes due to a condition such as paralysis or senility, critical decisions about the patient would be made without his consent.

The utilitarian framework for medical care debates the right of the individual against the public interest. One must consider who would be involved in the debate, how the public interest would be determined, and the ramifications of such involvement.

It is possible to approach the problem from a socio-economic standpoint, utilizing the cost-benefit analysis approach. "The life of the dying patient becomes steadily less complicated and less rewarding, and, as a result, less worth living or preserving. The pain and suffering involved in maintaining what is left are inexorably mounting, while

the benefits enjoyed by the patient himself, or that he can in any way confer on those around him, are just as inexorably declining. As the costs mount higher and higher and the benefits become smaller and smaller, one may well begin to wonder what the point of it all is."<sup>3</sup> The moment when it would no longer be worthwhile to maintain a patient's life would be the point at which the rising cost and declining benefit curves intersect.

Inherent in such an equational approach to health care is the question whether health and life in some cases are an expensive privilege for the physically, socially fit, as determined by experts. Some fear that such subordination of medicine to social and economic needs rather than to individual, human ones compromises the medical profession's integrity and increases the possibility of having medicine subordinated to political needs as well. If there were to be political control, the category of expendable people could be extended from the sick to those deemed socially, politically, or racially undesirable.<sup>5</sup>

The patient's family may be involved in the life-or-death debate. Financial cares are often influential. If the family members have plentiful funds to prolong the patient's life, they may not hesitate to do so; if extending his life is a financial burden, they may wish otherwise. This situation raises the question whether health and life is a right or a purchasable commodity. The family may also be confused about medical aspects of the case, and thus not make an informed decision. Motivations such as feelings of guilt or malice can enter into the decision-making process, as well.

If physicians were to attempt to determine, on the basis of comparative medical evaluations, which patients had most chance for recovery and would therefore be treated, the result would be a shift in the orientation of the medical profession. Physicians would no longer serve the interests of the patient, but of society; physicians would not be providers of aid and comfort for the ill, but technicians of rehabilitation. Another problem which could arise is self-interest or conflict of interest.

Perhaps the most balanced, integrated approach possible for considering who would receive medical attention is the group decision. There is such a group in Seattle, which decides which patients will be accepted for dialysis treatment. The group is made up of physicians, a lawyer, a housewife, a businessman, a labor leader, and a minister. Thus, the community participates. The group

"considers two bases for selecting patients: the medical-psychological aspect and the social-moral, rehabilitation one . . . In choosing candidates, they consider 'worth to the community'."<sup>6</sup> For example, a thirty-two-year-old man with a family of six to support and a stable history of employment was chosen over a forty-five-year-old widow whose children were grown up and had left home.

With increasing technological power has come methods of prolonging life and treating illness which tend to impoverish the context in which people die. Fewer and fewer people die in the company of family, friends, or even medical personnel. "At that time of life when there is perhaps the greatest need for human warmth and comfort, the dying patient is kept company by cardiac-pacemakers and defibrillators, respirators, aspirators, oxygenators, catheters, and his intravenous drip. Ties to the community of men are replaced by attachments to a community of machines."<sup>7</sup> The situation has fostered the suggestion of a new right to *die with dignity*, a right which would have several components and which might entail euthanasia.

Protagonists of negative euthanasia as defined, state that death with dignity means that the patient must be told the truth about his condition if he wants to know it; he must be cognizant of his approaching death so that he can individualize it by making decisions. He may have arrangements, accounts, or promises to settle, religious ceremonies to perform, and loved ones to bid farewell. Another component of a death with dignity is human company and caring, they state. A third ingredient is to die unmolested by bothersome treatments, once they are judged useless in the particular case.

Does a death with dignity include the right to be mercifully killed? In some cases, such as protracted untreatable pain, the hastening of death may be thought necessary for a dignified death, and may be an extreme act of love. The idea of a death with dignity is solely beneficent for the patient; therefore, euthanasia would have to be considered only in terms of his interests. The patient, in sound mind, would have to spontaneously request such assistance, or have made previous, explicit arrangements concerning euthanasia.

In the eventuality that euthanasia were permitted under carefully scrutinized, supervised conditions, it would be difficult to establish a patient's *right* to be mercifully killed. Rights imply responsibilities, and if a patient had a right to be killed,

a loved one or a physician would have the responsibility to kill him. While physicians have traditionally refused to kill, but have allowed patients to die when only extraordinary means would prolong life, it is not far removed from the humanitarian orientation of medicine, with the physician acting in the interests of the patient as a proxy, to hasten a terminal patient's death under special circumstances and when he requests it.

As can be seen, the morals, ethics, and dilemmas confronting the individual physician and the medical profession as a whole comprise a constellation of factors. Society as a whole will decide sometime in the future whether negative euthanasia will become accepted practice despite the protestations of segments within society. Without attempting to be judgmental, it is self-evident that the burden of the vital decision should not rest upon the individual physician. It is imperative that medicine maintain its role of healer, rather than executioner, if the public is to maintain its high degree of confidence in the profession. What must be decided, then, is who is to "bell this cat." It is suggested that hospitals consider formation of committees composed of administration, clergy, sociologists, and other community representatives of high repute, to whom the physician could address the facts of the individual case at the request of the family. If the committee decision is to "pull the plug," it is further suggested that the physician should withdraw from the case. Thus, society could best be served by having a decision made on its behalf implemented by a cross-section of its own composition.

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